AMBANI CENTER FOR OBGYN & AESTHETICS

7400 Fannin St., Suite 840, Houston, TX 77054
Phone: (713) 272-7600 Fax: (713) 272-7650

REGISTRATION FORM			
Last Name **First Name**		**DOB:**	**S.S.N:**
Address:			**Apartment #:**
City:	State:	Zip:	Home Tel:
Cell:	Work:	Email:	
Employer:		Occupation:	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Race: □ American Indian □ Alaskan Native □ Asian □ Black □ Caucasian □ Other □ Pacific Islander			
Ethnicity: □ Hispanic □ Non-Hispanic			
Spouse / Parent / Guardian's Name:		**DOB:**	**S.S.N:**
Cell:	Employer:	**Emergency Contact Name:**	
Referred to our office by:		**Relationship:**	**Cell:**

INSURANCE INFORMATION – *Please list all Insurance Policies*	
Primary Insurance:	**SELF PAY**: ☐ **Yes** ☐ **No**
Primary Insured's Name:	ID No:
Primary Insured's DOB:	Group No:
Provider Services Phone No:	Effective Date of Insurance:
Are you covered by more than one insurance policy ☐ Yes ☐ No If Yes, please provide above information for additional Policy	

PHARMACY		
Name:	**Address:**	**Phone:**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize Ambani Center for OBGYN & Aesthetics to disclose my personal health information to the persons listed above as Spouse / Parent / Guardian, Emergency Contact and my immediate family members**.** Should I wish to revoke this authorization or exclude specific persons I shall do so in writing.

The above information is true to the best of my knowledge. I authorize my Insurance benefits be paid directly to Ambani Center for OBGYN & Aesthetics who will file claims to my Insurance company, however I shall remain financially responsible for any balance. I also authorize Ambani Center for OBGYN & Aesthetics to release any information required to process my claims.

_____ _____

Patient / Parent / Guardian Signature ***Date***

OFFICE POLICY

1. Patient is responsible for all fees not covered by their Insurance carrier. Any disputes regarding the Patient responsibility should be directed to the Insurance carrier.
2. If the Patient's Insurance carrier is asking for additional information from the Patient/Insured, the Patient must furnish the information without delay. Any delay in furnishing the required information may result in a denial of the claim and/or the claim may become time-barred for the Secondary Insurance, if any. In this case, the Patient will be responsible to pay the balance.
3. Patient must report any changes to her name, Insurance carrier, address, phone number, contact information, etc. in writing without delay. If you are covered by more than one insurance policy, you must provide details of other policies, failure to disclose could result in you being fully responsible for all charges.
4. A service charge of $25.00 will be charged for each returned check.
5. The Patient is responsible for any omission or any incorrect information given to this office.
6. Non-compliance with plan of care may result in termination of Physician-Patient Relationship.
7. **Cancellation of scheduled surgery** requires 24 hours' notice. Because of the necessary supplies and equipment allotted for surgical procedures as well as administrative time required for pre-authorizations, any cancellation not made prior to the 24 hours will be subject to **a fee of $250.00**. This fee will not be billed to insurance and it is the patient's responsibility.
8. This practice utilizes covering Physicians during after office hours, weekends, holidays, travels or at any time when your physician is otherwise unable or unavailable for your medical care, these Physicians could be male or female Physicians, by signing below you consent to medical care by such Physicians.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my heath information.

CONSENT FOR PHOTOGRAPHS AND VIDEO RECORDING

I consent to photographs, audio and video recordings of me being recorded for patient care, security purposes, marketing and/or the practice/clinic's healthcare operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific authorization from me or my legal representative unless otherwise permitted or required by law.

CONSENT TO EMAIL, CELLULAR TELEPHONE OR TEXT COMMUNICATION

We want to stay connected with our patients by signing below, you consent that we may send medical, promotional, marketing related correspondence to you via email, cellular telephone or text including using third party vendors, and that we may respond to your emails to us via email.

INSURANCE AUTHORIZATION

I hereby authorize Ambani Center for OBGYN & Aesthetics to furnish my personal and healthcare information to the Insurance Carriers concerning my treatment and illness for purposes of billing and payment to the provider for services rendered.

LETTERS / RECORDS / COPIES / FEE POLICY

Letters requested by the Patient such as Immigration letters, Excuse letters other than our standard excuse letter, will be subject to a fee of $25.00, FMLA Forms will be charged $25.00. Request for Medical records by the Patient will be subjected to a fee of $25.00 up to the first 20 pages and $0.50 per page thereafter plus reasonable postage charge. Generally, we mail medical records by Certified Mail-Return Receipt to the Patient's residential address. If you need records you must clearly write your mailing address, phone number and your date of birth, social security number etc. in the records request. Once we release your records to you, you will be responsible for them.

OUT-OF-POCKET EXPENSES

Deductibles, Co-payments, and Co-Insurance amounts are "**out-of-pocket**" expenses and are YOUR responsibility to pay. As these amounts are subject to change without prior notification, we may not always ask you to pay the correct amount at the time of your visit. Anything we ask you to pay at the time of service is an ***estimate*** of what you will owe. If we have asked you to pay less than the correct amount shown on the explanation of benefits from your Insurance Company, we will bill you for the difference. Should you have any questions, please refer to your plan booklet or you may contact your employer, Insurance agent, or Insurance Company.

- **Payment of your out-of-pocket expenses is due at the time of service prior to you seeing the Doctor**
- **Obstetrical Patients are required to pay their out-of-pocket expenses before 26 weeks of pregnancy**

RELEASE OF INFORMATION

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

I have read, understand, and agree to all of the above policies and authorization.

Signature: _____ Date: _____